(Must be on company or physician letterhead)

Form to Verify Hours of APRN Practice

TO: Arkansas State Board of Nursing, Advanced Practice Department

I confirm that_____ , APRN, has completed approximately _____ hours of practice (as an APRN) within the last two (2) years.

Physician/APRN or
Clinic Representative Name &Title_____
Printed name & title

Physician/APRN or
Clinic Representative Signature_____
Signature

Date_____

AFFIDAVIT VERIFYING SIGNATURE (Above)

State of_____**County of** _____

Sworn to before me this _____ **day of** _____ **20**____

My Commission Expires _____

Notary Public Signature_____

Notary Seal